

On-The-Job Training for Family Planning Service Providers

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JHPIEGO Strategy Papers are designed to summarize JHPIEGO's experience in reproductive health, with a focus on education and training. The papers are intended for use by program staff of JHPIEGO, USAID and its cooperating agencies and other organizations providing or receiving technical assistance in the area of reproductive health training.

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Introduction

The goal of clinical family planning (FP) training is to assist health professionals in learning to provide safe, high-quality services to clients through improved work performance. This training should be competency-based and designed and conducted according to adult learning principles—it should be interactive, relevant and practical (Sullivan et al 1995).

Additional key features of effective clinical training are that it:

- Employs **mastery learning** which enables the participant to have a self-directed learning experience, with the clinical trainer serving as a facilitator
- Is built around the use of **coaching**
- Uses **humanistic** training techniques which facilitate learning new skills
- **Standardizes** the skill to be learned
- Emphasizes continual **assessment** of participant learning

Clinical training must focus on essential, need-to-know information and skills that can be used immediately in the provision of quality services. Such training involves the transfer of knowledge, skills and attitudes from the proficient clinical trainer to the individuals participating in training.

JHPIEGO's approach to clinical training for reproductive health and family planning professionals has four

critical elements which must be present in order for participants to become competent service providers:

- Knowledge transfer and assessment
- Skill transfer and assessment using anatomic models and role plays
- Skill transfer and assessment with clients
- Attitude transfer through behavior modeling by the trainer and interaction with clients

The most common type of training event is the traditional, group-based course which is usually short, intensive and designed for a large number of participants. But traditional or conventional classroom training often is unable to keep pace with the quantity of information to be updated and transferred to workers (Martin 1991). Smith (1995) states that an alternative to group-based FP clinical training that is more sustainable and able to accommodate small numbers of trainees must be developed. The purpose of this strategy paper is to compare traditional, group-based training to an on-the-job training (OJT) approach.

Group-Based Training

Key characteristics common to JHPIEGO's group-based clinical skills courses are listed below.

- Individuals with the prerequisite knowledge, skills and interest are selected to attend a course. They receive a reference manual and course handbook which includes the course syllabus, goals, objectives, participant selection criteria and course schedule.

¹ JHPIEGO's model for training clinical trainers is presented in the reference manual *Clinical Training Skills for Reproductive Health Professionals* (1995).

- In order to focus clinical training on essential (need-to-know) information, trainers use a training package which contains the reference manual, course handbook for participants, course notebook for trainers, course-specific audiovisuals (slide sets and videotapes) and other training aids (anatomic models).
- Trainers at the course site transfer the necessary knowledge and skills to the participants through a series of classroom presentations based on a reference manual. These sessions are highly participatory, interactive and use a variety of training materials, anatomic models and audiovisuals.
- Pre- and midcourse questionnaires are administered to ensure that the knowledge transfer process is effective.
- Learning guides and checklists are used to measure clinical skills or other observable behaviors relative to a predetermined standard. Learning guides are used to facilitate learning the steps or tasks (and sequence if necessary) in performing a particular skill or activity. Checklists are used to evaluate performance of the skill or activity objectively.
- Participant progression through the course is based on demonstrating competence rather than on the amount of time in attendance or the number of procedures performed.
- The clinical trainer demonstrates service delivery skills (e.g., counseling, IUD insertion and removal) using clinical role plays and anatomic models. The steps to perform these skills are outlined in learning guides that participants follow during demonstrations and practice sessions.
- As participants practice their newly acquired skills using anatomic models, the clinical trainer functions as a coach and observes, provides feedback and ensures that the transfer of skills is effective. In addition, participants guide and assess each other using a practice checklist. This is essentially the same checklist the trainer uses as a final evaluation tool to determine if s/he is competent at performing the counseling and clinical skills.
- When the participants have attained beginning skill proficiency using models, they move to the clinic. The trainer demonstrates the procedure with clients while one or more participants observe and refer to the checklist as a reminder of key steps. As participants apply their newly acquired skills with clients, the clinical trainer continues to function as a coach and observes, provides feedback and ensures that the counseling and clinical skills are being performed correctly.
- During the last 2 to 3 days of the course, the trainer uses a checklist to evaluate each participant to determine if s/he is competent in performing the clinical and counseling skills.
- Participants demonstrating mastery of knowledge (i.e., achieving at least 85% correct on the midcourse questionnaire), skills (i.e., correctly performing the steps in the checklist) and practice (i.e., providing services competently to clients in the clinic) receive a statement of qualification which identifies the knowledge and skills mastered during the course.

Can the group-based approach to training be an effective process? Yes! Is it the best method for transferring knowledge, attitudes and skills? Perhaps, but it will depend on the specific situation. When

considering a group-based training approach, it is important to take into account the advantages and limitations listed in **Table 1**.

Table 1—Advantages and Limitations of Group-Based Training

Advantages	Limitations
Being part of a group can generate excitement and a feeling of camaraderie among participants.	A group-based course requires a minimum number of participants.
Participants learn from each other.	Participants requiring training must wait for the next scheduled course.
Interaction among participants can add richness and depth to the training experience.	Generally, costs associated with facilities, travel, etc. are high.
The trainer is able to focus her/his full attention on the training process.	A large client caseload is needed at one time in order for all participants to have adequate clinic experience.
The trainer is able to assure the quality of training.	Large quantities of materials and supplies must be obtained and stored.
Participants are available to take part in demonstrations, role plays and to assist with coaching each other.	Trainers may have limited options when an inappropriate participant attends the course
Group-based training courses provide positive recognition to both the clinical training site and the participants.	Participants must stop providing services at their clinical site in order to attend training.
It is easier to standardize knowledge and skills as all participants receive the same information in the same way.	Program demands for a large number of trained service providers may not be met.

On-the-Job Training

On-the-job training (also referred to as site-based or clinic-based training) is a form of individualized training and allows the individual requiring training to receive the necessary knowledge and to develop the required skills on the job. A review of the literature indicates that OJT can be designed and delivered using two basic approaches. Those OJT programs with little or no prior planning which pair a worker to be trained with an experienced worker are referred to as unstructured, informal or unplanned OJT experiences. Those programs built on an organized process are known as structured, formal or planned OJT experiences.

Jacobs and Jones (1995) indicate that unstructured OJT occurs when trainees acquire job knowledge and skills from impromptu explanations or demonstrations by others, trial and error efforts, self-motivated reading, or simply by imitating the behavior of others. In medical training this is often referred to as “See One—Do One—Teach One.” Rothwell and Kazanas (1994) define unplanned OJT as training which occurs on the work site but is not logically sequenced. In unplanned OJT, the learners are expected to learn by watching experienced workers perform or by actually doing the work themselves.

According to Jacobs and Jones (1995), there are a number of problems with unstructured OJT as used in many business and industrial settings. These include:

- The desired skill level is rarely achieved (i.e., lack of measurable standards).
- The training content is often inaccurate or incomplete.

- Experienced employees are seldom able to communicate what they know in a way that others can understand.
- Experienced employees use different methods each time they conduct training (i.e., lack of a standardized training approach).
- Many employees fear that sharing their knowledge and skills will reduce their own status as experts.

According to several studies conducted by Jacobs and Jones (1995), unstructured OJT leads to increased error rates, lower productivity and decreased training efficiency. They favor a structured approach to on-the-job training which is defined as:

The planned process of developing task level expertise by having an experienced employee train a novice employee at or near the actual work setting.

They also stress that in structured OJT, the training content, methods and outcomes are consistent for all employees. This requires a standardized approach not only to specific knowledge and skills, but to the delivery of on-the-job training as well.

Rothwell and Kazanas (1994) define planned on-the-job training as:

Planned instruction occurring on the job and during the work, centered around what workers need to know or do to perform competently.

Based on the success of structured OJT (Marsh and Pigott 1992; Mullaney and Trask 1992; Martin 1991), JHPIEGO staff are exploring this approach for training FP service providers on the job.

Characteristics of Structured OJT

The ultimate success of structured OJT depends on the organization's commitment to improving training quality (Mullaney and Trask 1992). The authors stress that a successful OJT program is one that is used in appropriate situations and ensures that OJT trainers have the appropriate technical competence and extensive work experience. They also feel that OJT trainers should have organizational support and receive training to be an OJT trainer. The successful OJT program is one that is based on an effective training model.

These conditions are consistent with JHPIEGO's competency-based approach to clinical training. Restating these conditions using JHPIEGO terminology produces a similar set of conditions.

- OJT should be used in appropriate situations. On-the-job training is not meant to be a substitute for group-based training.
- OJT clinical trainers must be experienced, proficient service providers with an interest in training other service providers.
- OJT clinical trainers must have their clinical skills standardized and their FP knowledge updated, and they must receive training in how to be an OJT trainer (e.g., giving demonstrations, using learning guides and checklists, coaching, using models for training).
- OJT clinical trainers must have the support of staff at the training site (e.g., clinic, hospital) as well as the support of regional- and national-level training experts.

Reynolds (1995) describes elements that should be built into a formal or structured OJT program. These

are performance objectives, a schedule, assignment to a qualified employee for training and a performance checklist that must be signed off as each objective is met. Once again, these are consistent with JHPIEGO's approach to group-based training, which also includes performance objectives, a schedule and a checklist used to measure skill competence. According to Levine (1995), effective OJT training should:

- be structured, meaning that OJT materials, training guides and performance checklists have been prepared and that the trainers have been trained,
- be timely (i.e., delivered when and where needed),
- include development of training schedules and afford trainers adequate preparation time,
- be consistent (i.e., the knowledge and skills transferred do not vary from trainer to trainer and all trainees are expected to master the same set of core skills), and
- ask evaluation questions such as "Do trainees know what is expected of them?" and "Are there standardized performance evaluations for all major tasks?"

In addition, OJT trainers should be sensitive to the needs of the trainees and content and time requirements, able to change instructional strategies as required by the trainee and able to coach trainees until they can perform the tasks successfully.

Marsh and Pigott (1992) offer four major suggestions for improving on-the-job training:

- Develop performance-based training objectives that describe what participants will be able to do after training.

- Use brief performance checklists that are accurate, uniform and well-organized.
- Teach the individuals responsible for training about how people learn and how to facilitate learning.
- Verify learning with checklists after training.

In a recent presentation at a national conference for trainers, Levine (1995) outlined the types of materials required for an effective, structured OJT program.

These include:

- A student training manual or guide which describes the responsibilities of all participants in the OJT process, lists the tasks to be learned,

provides organization for the learning process and contains reference information and job procedures.

- A trainer's manual which contains essentially the same information as the student's, with the addition of the standardized evaluation instruments for each skill.
- The training aids necessary for the learning process (e.g., visual aids, examples, items used on the job).

There are advantages and limitations of using on-the-job training (**Table 2**). These must be taken into consideration before deciding to use this approach for preparing FP service providers.

Table 2—Advantages and Limitations of OJT

Advantages

Participants can be trained immediately without waiting for a scheduled course.

Clinic personnel control training quality.

Training can be designed to meet local needs.

It is easier to obtain a sufficient client caseload to ensure adequate clinic experience.

The problem of inappropriate trainee selection (e.g., political decision, lack of interest in training) is avoided.

Once installed, OJT may be more sustainable than traditional group-based training.

OJT is more cost-effective than traditional group-based training.

OJT is most effective at sites where there is staff turnover or where large numbers of clinicians require training.

Limitations

There is limited interaction compared to group-based training.

There may be a tendency to revert to "see one, do one, teach one" instead of following the steps in the OJT program.

Maintaining quality of training at a national level can be difficult.

Limited reading abilities of the participants may create problems since there is less interaction with the trainer.

In the early phases of training when participant skills are weak, there may be a tendency to practice skills with clients in the clinic instead of with anatomic models.

Training needs of the OJT trainers must be met.

It may not be cost-effective at sites where there is limited turnover of staff.

Selecting and Training OJT Trainers

One of the characteristics of unstructured on-the-job training is that trainers typically are not prepared to be trainers. This is not the case in a structured OJT program. According to Levine (1995), training of the OJT trainer is the key to successful implementation. This training builds training skills, ensures commitment to the program and helps trainers learn to use the training materials. Levine states that the program should contain high-impact exercises to change trainer behavior from telling to coaching, from demonstrating skills for trainees to performing them with them.

Jacobs and Jones (1995) identify eight qualities to look for when selecting an OJT trainer. These include:

- Task knowledge and skills—ability to perform the work behaviors at appropriate performance levels
- Specialized training—completion of specialized training in the area that will be the basis of the OJT program
- Willingness to share their expertise—interest in the development of others
- Respect from peers—perception by other employees that the trainer has task expertise, leadership abilities and general problem-solving skills
- Interpersonal skills—ability to communicate clearly and comprehensively
- Literacy skills—ability to comprehend resource materials
- Concern for the organization—showing an interest in helping the organization improve its performance
- Job expectations—awareness of job expectations and assignments and how these will affect their ability to perform as an OJT trainer

A FP trainer must first be a proficient service provider. For example, an IUD clinical trainer must be knowledgeable about counseling, the standard IUD insertion and removal techniques and appropriate infection prevention practices. In addition to being a proficient service provider, the OJT clinical trainer must be able to:

- demonstrate an understanding of the competency-based approach to clinical training
- create a positive OJT training climate
- use interactive OJT training techniques
- use competency-based learning guides and checklists
- demonstrate clinical skills during role plays with models as well as with clients
- coach in a clinical setting
- assess clinical skills and determine if a service provider is qualified to provide a FP service

There are two approaches to preparing an OJT trainer. The first is a group-based OJT clinical training skills course during which the proficient service provider's knowledge and skills would be updated and standardized and the provider would learn to be an OJT trainer. In some situations this may not be possible and, in fact, can defeat the purpose of moving to an on-the-job training approach. The second approach allows the proficient service provider to learn the skills on the job to be an OJT trainer. This approach requires that an outside supervisor provide a set of materials to the proficient service provider

interested in becoming a trainer and then periodically meet with this person to discuss, demonstrate and practice the essential OJT clinical training skills. The supervisor will also need to ensure that the service provider is proficient and that her/his clinical knowledge and skills are up-to-date and standardized. The specific steps in training of the OJT trainers (and supervisors) will vary depending on the needs of the situation and the final design of the OJT program.

Implementing an OJT Program

Levine (1995) offers a number of issues to consider when implementing an on-the-job training program. It should be highly structured and require a high degree of accountability of all participants (e.g., trainer, trainee, supervisors, administrators). In addition, there must be adequate support for the OJT program in the form of supplies, funding, training materials and recognition of trainers and trainees.

According to Smith (1995) there are a number of factors to consider in developing and implementing an on-the-job training program.

- Analyze current conditions and then ensure OJT clinical facilities are adequate to support training.
- Ensure the environment within the training site is one that encourages service providers to be mentored as they participate in the OJT program.
- Ensure that there is a demand for on-the-job training by the service providers at the training site.
- Develop a system to ensure that trainers and service providers in training are supervised by a qualified supervisor either from within the

training site or by an outside regional or provincial supervisor. This is one of the most critical factors in successfully implementing an OJT program. The specifics of this system will differ depending on the situation and must be taken into consideration during the design of the OJT program.

- Train supervisors and trainers to use the OJT training materials.
- Orient others within the training site (e.g., administrators, supervisors, matrons, medical staff, support staff) to both the on-the-job approach to training and to the family planning method (e.g., IUDs, Norplant implants).
- Develop a plan for qualifying those service providers successfully completing the OJT program. The qualification criteria are the same as for the traditional group-based training course (e.g., score at least 85% on the midcourse questionnaire, perform clinical skills according to the competency-based checklists, provide services to clients appropriately).

Evaluating OJT

Does on-the-job training work? Can service providers trained through OJT perform as well on the job as service providers trained in a traditional, group-based approach? Smith (1995) states that an evaluation of OJT should focus on both process and impact. She also stresses that it is important to document whether there is a substantial difference between the approaches in the knowledge and skills acquired during training.

Pacquin (1995) states that evaluation of job skills is critical to a training program's credibility. In unstructured OJT the evaluation or assessment of job skills

either does not exist or is done through informal observations only. Pacquin argues that measurement of trainee performance must be deliberate and consistent, and describes a job performance measure (JPM) which is used to document task knowledge and performance during on-the-job training. Components of a typical JPM include the following:

- Precautions and warnings relative to the skill being performed
- List of tools and equipment needed to perform the task or skill
- Procedure for task completion (e.g., list of the steps to be performed)
- Standards for performance of steps (i.e., criteria or standards to which steps/tasks must be performed)
- Knowledge-based questions (e.g., a knowledge-based test covering the training content)
- Spaces for administrative information such as trainee's name, date and trainer's name

Description of an OJT Program for Family Planning

Based on the information presented in this paper, the following description of an OJT program for learning to provide IUD services is presented.

- Based on a training needs assessments, a decision is made to increase the number of IUD service providers through an on-the-job training program. The materials are developed and a system for implementing, supervising and evaluating the OJT program is designed.
- A FP clinic is selected as a site for OJT based on the needs assessment as well as client caseload

and interest of clinic staff. A proficient IUD service provider who is interested in becoming an OJT trainer receives a packet of materials describing in detail the program structure and the roles and responsibilities of the trainer and the clinicians being trained. This OJT trainer may attend a formal, group-based IUD clinical training skills course or may meet with a regional OJT supervisor to learn more about being a trainer.

- A clinician at the clinic is selected to be trained in IUD service provision.
- The clinician (participant) meets with the OJT trainer to discuss the program structure, schedule, objectives, assignments, and knowledge and skill evaluations. The participant receives a set of materials including an IUD reference manual and a participant's workbook which describes each of the steps in the OJT process. The workbook also contains practice exercises or assignments the participant will complete after reading information in the reference manual.
- The participant takes a precourse questionnaire which is based on the content in the reference manual. The trainer scores the questionnaire using the answer key in the trainer's notebook and reviews the results with the participant. This allows the participant and trainer to identify those areas where the participant has knowledge and those areas where more study will be required.
- The participant's counseling and clinical skills are observed through role play and performance using the pelvic model. Skill assessments may include performing a pelvic exam, loading the Copper T 380A IUD in the sterile package and

IUD insertion and removal. Knowing what skills the participant already has can make the OJT process easier.

- The participant begins the individualized knowledge transfer process (i.e., learning the content) by reading the appropriate sections of the participant's workbook. When the participant is ready to begin individualized study, s/he follows the series of steps listed in the workbook.
- The participant reads the appropriate chapters in the IUD reference manual and completes the corresponding exercises in the workbook. The participant receives feedback on the completed exercises either by looking at the answers in the workbook or by discussing the exercises with the OJT trainer. Periodic meetings are scheduled with the trainer to discuss questions related to the information in the reference manual.
- When the participant has completed all of the required readings and practice exercises in the reference manual, s/he takes the midcourse questionnaire. The trainer scores the questionnaire and reviews the results with the participant. In some situations, a regional OJT supervisor may administer and score the midcourse questionnaire. If the participant scores at least 85% correct, then the participant has mastered the knowledge portion of the course. If the score is less than 85%, the trainer will identify those areas requiring additional study. The participant studies these areas and repeats the knowledge assessment until a score of at least 85% is achieved.
- At the point indicated in the OJT workbook, the participant meets with the trainer for a demonstration of the IUD counseling process. The

trainer and participant review the steps outlined in the counseling learning guide and view a videotape of a counseling session if one is available. Following the demonstration, the participant practices the counseling steps during a series of role plays either with the trainer or with another staff member. The trainer functions as a coach and observes and provides feedback as the participant practices.

- When the participant feels comfortable with the counseling process, the trainer uses a checklist to evaluate her/his competency during a role play.
- Once the trainer determines that the participant is competent during the role play, the participant observes the trainer counseling a client in a clinic setting. The participant then counsels several clients as the trainer (now serving as a coach) observes and provides feedback. When the participant feels comfortable counseling clients, the trainer evaluates her/his skills to determine if the participant is competent.
- At the point indicated in the OJT workbook, the participant meets with the trainer for a demonstration of IUD insertion and removal using an anatomic model. The trainer and participant review the steps outlined in the learning guide and view a videotape or set of slides showing the procedures, if they are available. Following the demonstration, the participant practices insertion and removal using a model. The trainer functions as a coach and observes and provides feedback. When the participant feels comfortable with the insertion/removal procedures on a model, the trainer evaluates her/his skills with a checklist to determine competency.

- Once the trainer determines that the participant is competent with models, the participant observes the trainer working with a client in a clinic setting. The participant then inserts and removes IUDs with several clients while the trainer, as coach, observes and provides feedback. When the participant feels comfortable with the process, the trainer uses a checklist to evaluate her/his skills to determine if s/he is competent. If appropriate, a regional OJT supervisor may evaluate the participant's skills.
- Once the participant has demonstrated mastery of the required knowledge and skills, s/he receives a statement of qualification which identifies the knowledge and skills mastered during the OJT course. The statement of qualification may be presented by the local trainer or a regional OJT supervisor.
- Skill transfer and assessment with clients
- Attitude transfer through behavior modeling by the trainer and interaction with clients

With these elements present, an OJT approach may be a viable alternative to group-based training courses.

Summary

On-the-job training can be an effective method for preparing FP service providers. OJT offers many advantages, especially when large numbers of service providers need to be trained or when they are widely dispersed, making group-based training very expensive. If the OJT system is poorly designed, the trainers/supervisors poorly prepared, or a system is not in place to support the OJT process, however, clinicians are likely to return to the “see one, do one, teach one” approach and the quality of training will suffer. The following elements critical to group-based training must also be present in any on-the-job training program:

- Knowledge transfer and assessment
- Skill transfer and assessment using anatomic models and role plays

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